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ABSTRACT

Only 447 cases of Acquired Immune Deficiency Syndrome (AIDS) among 13- to 19-year-olds were reported to the Center for Disease Control through November 1989; however, 20 percent of the reported AIDS cases among males and 25 percent among females were diagnosed in people ages 20 to 29. Because of the long incubation period between infection and the onset of symptoms, many of these adult AIDS victims are the result of infection during the teenage years. To assess the progress toward implementing Human Immunodeficiency Virus (HIV) education programs in elementary and secondary schools, and to determine the extent to which comprehensive (K-12) school health education is required, in April 1989 questionnaires regarding prevention education programs were sent to the superintendents of 568 school districts throughout the United States. The response rate was 59 percent. Results of the survey indicated that: (1) of the 79 percent of responding school districts that required HIV prevention education, 56 percent reported high parental support for the program; (2) most districts required HIV education in grades 6 through 8; and (3) the small/rural districts were somewhat more likely than urban and large/suburban districts to include communication skills, peer pressure resistance, self esteem, and child abuse counselling in their HIV education curriculum. Appended are the responses to the HIV Prevention Education Survey. (KM)

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HIV PREVENTION EDUCATION IN THE NATION'S PUBLIC SCHOOLS

Report of the National School Boards Association Survey

February 1990

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HIV PREVENTION EDUCATION IN THE NATION'S PUBLIC SCHOOLS
Report of the National School Boards Association Survey

National School Boards Association

James R. Oglesby, President
Thomas A. Shannon, Executive Director
Hal P. Seamon, Deputy Executive Director

Office of Federation Member Relations, State Legislation and Public Policy

Michael E. Eader, Associate Executive Director
Martharose F. Laffey, Assistant Executive Director
Dale Gaddy, Director, Leadership Training Center
Adria L. Thomas, Director, Research and Information Services
Brenda Z. Greene, Manager, AIDS Education
Eve Shepard, Manager, Leadership Training Center
Terry Chelednik, Manager, Research and Board Development
Mary Deitchmendi, Coordinator, AIDS Education
David Demchuk, Coordinator, AIDS Education

NSBA HIV Education Project Advisory Committee

Madeline M. Blue, Director, NSBA Board of Directors
Donald Calderon, Director, Policy and Information, New Jersey School Boards Association
Brian Dale, American Federation of Teachers
Patry Garriott, Immediate Past President, Tennessee School Boards Association
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Lou Ella Kleinz, Executive Director, Arizona School Boards Association
Ann Lynch, President, The National PTA
Cynthia Wolford Symons, American School Health Association
James Williams, Health Information Network, National Education Association

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Lloyd J. Kolbe, Director
Jack T. Jones, Chief, Program Development and Services Branch
Lisa Dally, Public Health Advisor
Laura Kann, School Health Education Specialist

Data analysis: Terry Chelednik, Mary Deitchmendi, Todd Lockhart
Editor: Brenda Z. Greene

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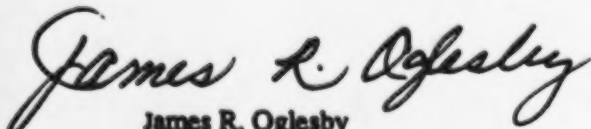
FOREWORD

This report demonstrates that the nation's schools recognize the need for HIV education to stop the spread of the HIV epidemic. But this report also presents a challenge to school leaders.

Not all schools are providing HIV prevention education. Not all schools that provide HIV education are preparing teachers adequately, are providing appropriate education to special education students, or are providing HIV education within the context of K-12 comprehensive health education. And not all school districts are enjoying high or even moderate levels of parental support for their HIV education programs.

Perhaps most useful to school leaders, this report identifies practices for implementing HIV education in a way that generates strong support from parents. These practices are no different from those used by school officials to make other sound decisions: planning that involves experts and members of the school community; communication with the school community about the subject and what the schools are doing; formal adoption of board policies that convey to the public the program's purpose and the value the school district places on achieving its goals.

We commend this report to you and urge that you use it to guide school district actions to establish more effective HIV education.


James R. Oglesby
President

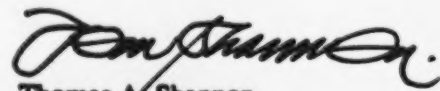

Thomas A. Shannon
Executive Director

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HIV PREVENTION EDUCATION IN THE NATION'S SCHOOLS

INTRODUCTION

Relatively few cases of AIDS (acquired immunodeficiency syndrome) among 13-19 year olds have been reported to the Centers for Disease Control (CDC) -- 447 through November 1989. However, 20 percent of the reported AIDS cases among males and 25 percent among females were diagnosed in people ages 20 to 29. Because of the long incubation period between infection with HIV and symptoms of AIDS, it is likely that many of these AIDS cases are the result of HIV infection acquired during the teenage years -- primarily from teenagers engaging in sexual intercourse and intravenous drug use.

Our nation's schools are being counted on to play a significant role in educating young people about the human immunodeficiency virus (HIV) and particularly about how to assess and reduce their risk of infection. This school responsibility is supported through various efforts.

Twenty-eight states and the District of Columbia require some form of HIV education for students according to a survey conducted by the National Association of State Boards of Education (May 1989). To help implement school-based HIV education, the Centers for Disease Control (CDC) provides funding to all state education agencies, to five territorial departments of education, and to 16 local education agencies in cities with a high cumulative incidence of AIDS cases. In addition, the CDC funds 19 national organizations, including the National School Boards Association (NSBA), to provide information and training to their constituencies which include school board members, school administrators, teachers, and parents, to help schools implement effective programs of health education about HIV.

Purpose of Survey

In the spring of 1989, NSBA surveyed school districts nationwide:

- to assess the progress being made toward implementing HIV education programs in elementary and secondary schools;
- to assess the extent to which comprehensive (K-12) school health education is required;
- to identify gaps in program development and delivery; and
- to identify practices that either support effective HIV education or inhibit its implementation.

The results of this survey will be used as baseline data to measure progress, to plan programs, and to design resources that can assist school officials to provide effective HIV prevention education.

Methodology

On April 17, 1989, the Questionnaire on HIV Prevention Education Programs was sent to the superintendents of 568 NSBA Direct Affiliate school districts representing urban, large/suburban, and rural/small districts throughout the United States. A companion letter was sent to the school board president in each district to solicit their support for the survey.

Because of a low response rate, a second mailing to the rural/small districts was sent on June 9, 1989. The final overall response rate for all districts surveyed was 59 percent, or 332 districts: 64 percent of the urban districts, 64 percent of the large/suburban districts, and 57 percent of the rural/small districts.

Limitations and Terminology

As described below, the 568 districts surveyed may not necessarily be representative of the more than 15,000 districts nationwide since they have increased interest in, and enhanced access to, information and services that assist them in responding to issues in a timely way. Fifty-nine percent of the 568 districts surveyed provided useable information. It is not known whether these districts are different in any important way from the 41 percent that did not respond. Thus, generalization of the results may not be appropriate. Nevertheless, the findings from these districts are important.

NSBA Direct Affiliate districts pay a fee to receive services provided by NSBA. These services include subscription to NSBA's fortnightly newspaper *School Board News* and the monthly newaletter *Updating School Board Policies*, discounts on other NSBA publications, access to the Educational Policies Service Information Clearinghouse, and reduced fees at educational meetings. The 568 districts surveyed (30 percent of all Direct Affiliate districts) are those Direct Affiliate districts that participate in either the Council of Urban Boards of Education (CUBE), the Large District Forum (LDF), or the Rural and Small District Forum (RSDF). Special programming is tailored to the particular needs of CUBE, LDF, and RSDF members.

CUBE is composed of school districts that are urban in nature and represent districts with a minimum core-city population of 100,000 residents. Over 70 of the 176 cities that meet this criterion participate in CUBE. CUBE districts are referred to as *urban* districts in this report.

LDF is composed of large school districts that are not strictly urban in nature. Many of these districts represent suburban communities; many others are large counties that encompass a city and its surrounding areas. LDF districts are referred to as *large/suburban* districts in this report.

RSDF is composed of rural and small school districts and intermediate or county units that primarily serve rural populations. These districts generally represent areas with population densities of less than 1,000 persons per square mile. RSDF districts are referred to as *rural/small* districts in this report.

Demographics

The number of schools in responding districts ranges from one to 275, with a median of five. The median number of schools in responding urban districts is 78; large/suburban districts, 33; and in rural/small districts, 3.

The student enrollment of responding districts ranges from 75 students to more than 400,000. Median enrollments are 1,845 overall: 1,050 for rural/small districts; 22,000 for large/suburban districts; and 42,584 for urban districts.

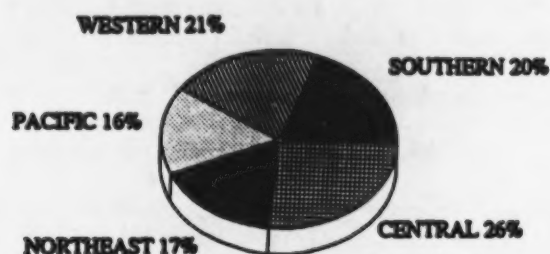
Structurally, 83 percent of the responding districts are K-12; 7 percent are K-8; 3 percent are K-6; and 2 percent are 9-12.

Responding districts are located in NSBA regions as follows:

- Twenty-six percent of the districts completing the survey are from the Central region: Illinois, Indiana, Iowa, Kentucky, Michigan, Minnesota, Missouri, Ohio, and Wisconsin;
- Twenty-one percent are from the Western region: Colorado, Kansas, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, South Dakota, and Wyoming;
- Sixteen percent are from the Pacific region: Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Utah, and Washington;

- Seventeen percent are from the Northeastern region: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and Virgin Islands; and
- Twenty percent are from the Southern region: Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

Figure 1. RESPONDENTS BY NSBA REGION



The 332 responding school districts are composed of 47 urban districts (14%), 57 large/suburban districts (17%), and 228 rural/small districts (69%). This composition, though not a precise representation, is in keeping with the characteristics of the more than 15,000 school districts nationwide. According to *Market Data Retrieval, 1989-90*, a market research publication, there are 1,335 urban districts (9%), 4,177 suburban districts (28%), and 9,527 rural districts (63%).

Highlights

The survey questionnaire (see Appendix) included questions on requirements for comprehensive school health education and HIV prevention education for general and special education students, content of the HIV education programs, community involvement practices, costs of the programs, awareness of adolescent risk factors, local policies, infection control procedures, and employee education. Highlights of the survey results include the following:

- Seventy-nine percent of responding school districts require HIV prevention education for their students. (Page 7)
- Responding districts that require comprehensive health education for their students (87%) are more likely to require HIV prevention education (83%) than are districts that do not require comprehensive health education (54%). (Page 7)
- Most of the responding districts began requiring HIV prevention education in either the 1987-88 school year (32%) or the 1988-89 school year (37%). (Page 7)

- Fifty-six percent of the responding districts that require HIV prevention education assess parental support for the program as high ; 33 percent assess parental support as moderate; only 7 percent state that parental support is low. (Page 7)
- Data indicate that parental support of HIV prevention education is positively related to community members' involvement in the development of HIV prevention education programs, to the use of community advisory committees, and to the official adoption of curriculum by the local school board. (Pages 8-9)
- Responding districts require HIV prevention education most often in grades 6 through 8. (Pages 9)
- At all grade levels, responding districts most often integrate HIV prevention education into the health education curriculum; stand-alone programs, such as assemblies, are used as an instructional vehicle most often for grades 11 and 12. (Page 10)
- Responding rural/small districts are somewhat more likely than urban and large/suburban districts to include communication skills (98%), resistance to peer pressure (100%), self-esteem (99%), and child abuse (88%) in their HIV education curriculum. (Page 11)
- Responding urban districts are the most likely to include in their HIV education curriculum discussion of condoms as a means of reducing the risk of HIV infection (97%) and the risks of unprotected anal intercourse (81%) and oral intercourse (76%). (Page 11)
- Responding large/suburban districts are the least likely to include discussions of homosexuality (68%). (Page 11)
- All responding districts include the following three topics in their HIV education curriculum: how HIV is *not* transmitted; fears and myths about AIDS; and abstinence from drug use. These subjects are most often introduced in elementary school. (Page 12)
- Topics that are most often first addressed by responding districts in the middle school curriculum are homosexuality, abstinence from sexual intercourse, use of condoms, and the risk of unprotected sexual intercourse (vaginal, anal, and oral). (Page 12)
- Ninety-four percent of the responding districts that require HIV prevention education allow students to be excused from all or part of the instruction upon a parent's request; 80 percent of these districts report that fewer than one percent of parents exercise this option. (Page 12)
- Responding districts report that the classroom teacher most often provides HIV instruction in kindergarten through grade six; in grades 7 through 12, a health teacher is the primary educator. The most significant use of school nurses as instructors is in grades 4 through 6; public health officials and community agency staff provide HIV prevention education most often in grades 9 through 12. (Pages 12-13)
- Eighty percent of the responding districts that require HIV prevention education for their general education students also require such instruction for special education students. (Page 14)

- Eighty-three percent of the responding districts requiring HIV prevention education provide relevant inservice training to teachers. Parental support of HIV prevention education appears to be positively related to provision of inservice training for teachers: of all districts with high parental support, 89 percent provide inservice training for teachers, but of all districts with low support from parents, only 53 percent provide such training. (Pages 14-15)
- Responding districts that require HIV prevention education for students provide instruction on HIV for all employees more often than do districts that do not require HIV education for students. (Page 15)
- Fifty-eight percent of the responding districts report allocation of funds for HIV prevention education; 38 percent of these districts spend the majority of funds on curriculum development, 30 percent on inservice training, and 21 percent on instructional materials. (Page 16)
- Sixty-eight percent of responding districts report allocation of funds to support infection control procedures. Sixty-nine percent of these districts spend the majority of funds on supplies, while 24 percent of the districts spend the majority of funds on training. (Page 16-17)

HIV PREVENTION EDUCATION IN ELEMENTARY AND SECONDARY SCHOOLS

Seventy-nine percent of the responding 332 school districts require HIV prevention education for their students; 18 percent do not require it, and 2 percent did not respond to the question.* Comprehensive health education is required as part of the curriculum by 87 percent of all responding districts. As might be expected, those districts that require comprehensive health education also require HIV prevention education (83%) more often than those districts that do not require comprehensive health education (54%).

Among the 61 responding districts that do not require HIV prevention education, 37 districts (61%) plan to do so in the future. Fourteen responding districts are not planning to require HIV prevention education. They cite the following reasons:

- They believe that the education is not needed (five districts);
- Their teachers are unprepared to teach the subject (four districts);
- The community does not support HIV prevention education in the schools (four districts);
- The school board does not support HIV prevention education (one district).

Of the districts that require HIV prevention education, 20 percent started providing instruction by the end of the 1986-87 school year, 32 percent started in the 1987-88 school year, and 37 percent started in the 1988-89 school year. Nine percent of the districts intend to begin providing instruction in the 1989-90 school year; 2 percent of the districts did not respond to the question.

Districts in the Northeastern region began their programs earlier: 68 percent of those districts instituted their curriculum before the start of the 1988-89 school year; 52 percent of the districts overall began before the 1988-89 school year. Only 34 percent of the Western region districts that require instruction began providing HIV prevention education before 1988-89: 57 percent provided such instruction in 1988-89 for the first time.

Urban districts also began their programs earlier than did large/suburban and rural/small districts. By the end of the 1986-87 school year, 46 percent of responding urban districts had implemented HIV education compared to 21 percent of large/suburban districts and 15 percent of rural/small districts.

Eighty percent of all responding districts that require HIV prevention education are mandated by state law to do so. In the Northeast, 93 percent of responding districts are so required, compared to 80 percent in the Southern and Western regions, 77 percent in the Pacific region, and 75 percent in the Central region.

Community Involvement

More than half (56%) of the responding districts that require HIV education state that parental support for the program is high, and one-third (33%) assess support as moderate. Only 7 percent state that parents are not behind their programs. High parental support is reported more often by urban districts (78%) than by large/suburban (55%) or rural/small (52%) districts.

* Percentages rounded to nearest whole number.

It cannot be determined from this survey whether concerned parents influenced the formation of school policies, programs, and curriculum, or whether active districts raised awareness in their communities and hence garnered greater support for their programs. Evidence exists, however, that districts with higher levels of parental support are more likely to include potentially controversial subjects in their curriculum.

Eighty-four percent of districts that report high levels of parental support include discussion of homosexuality in their curriculum compared to 68 percent of districts with low parental support. Similarly, districts with high parental support include discussion of vaginal intercourse (91%), anal intercourse (76%), and oral intercourse (73%) compared to districts with low parental support (68%, 58%, and 58%, respectively).

Most districts are likely to involve teachers (94%) and parents (79%) when developing or selecting curriculum. Seventy-one percent of the responding districts also indicate that they consulted public health officials when deciding on the curriculum; urban (89%) and large/suburban districts (85%) consulted public health officials more often than did rural/small (64%) districts. Somewhat less frequently involved are clergy (55%), community-based organizations (41%), and students (38%); urban districts (78%) involved community organizations significantly more than did large/suburban (55%) and rural/small districts (30%).

As shown in Table 1, as parental support for HIV prevention education increases, so does the proportion of districts that involved members of the community.

Table 1. Proportion of Districts Involving Various Community Members in Developing or Selecting Curriculum

Community Members Involved	Levels of Parental Support For HIV Prevention Education in School Districts		
	High n=148	Moderate n=86	Low n=19
Public Health Officials	78%	66%	53%
Teachers	95	97	90
Parents	85	79	47
Clergy	63	50	37
Students	48	27	21
Community Organizations	47	36	37

Seventy-two percent of the districts that require HIV prevention education formed advisory committees to review and recommend appropriate HIV prevention materials and concepts to be taught at various grade levels. Urban districts (87%) formed such committees more often than did large/suburban (77%) or rural/small (68%) districts.

Responding districts with higher parental support are more likely to have formed community advisory committees. Eighty-two percent of those districts with high parental support formed these committees, compared to 69 percent of those with moderate support and 32 percent of those with low support.

Nearly half (49%) of the responding districts that require HIV prevention education also have programs to educate parents about the disease. These programs are most likely to be found in the Southern region (63%) and least likely in the Central region (32%). Rural/small districts provide HIV education for parents less often (44%) than urban (60%) or large/suburban (60%) districts.

Parental support for HIV prevention education may be somewhat related to whether the parents themselves are educated about HIV; 53 percent of those districts with high parental support provide programs for parents; 48 percent of those districts with moderate support and 42 percent with low support provide such programs.

Curriculum

The HIV prevention education curriculum being used was board-approved in 89 percent of the responding districts that require HIV education. All (100%) of the districts requiring HIV prevention education in the Northeast report such approval, whereas 80 percent of those in the Southern region report that the school board had approved the curriculum being used.

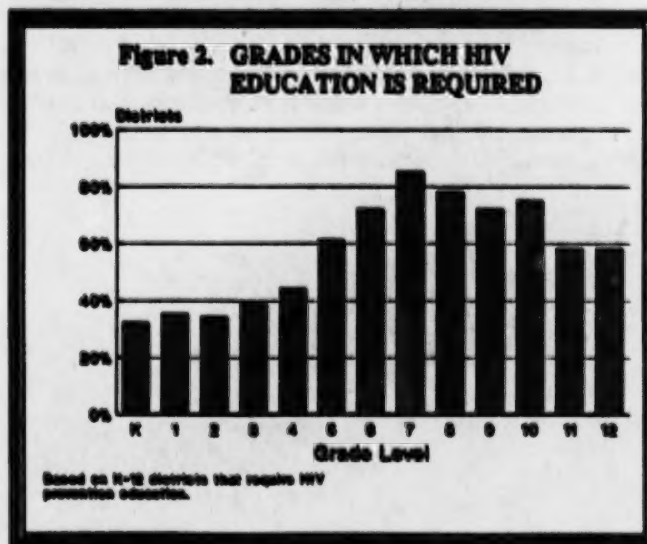
Board approval of the curriculum also appears related to parental support of HIV education. Districts that report support as high are more likely to use board-approved curriculum (93%) than districts that report parental support as moderate (87%) or low (74%).

The majority of responding districts (78%) that require HIV education use a curriculum developed within their own district. Over half (51%) have adapted the curriculum from other available curricula, and one-third (34%) use a curriculum developed by their state education agency. Only 15 percent of the districts requiring HIV prevention education purchased their curriculum.

Districts in the Pacific region are nearly twice as likely as are others to have purchased their curriculum (29% vs. 15%), whereas those in the Southern region are more likely than are others to use a curriculum developed by their state education agency (47% vs. 34%). Curriculum developed by the school district is more common in the Northeastern region (90%) than overall (78%).

Grade Levels

Information provided by responding districts about the grade levels in which HIV prevention education is required shows a definite trend. The proportion of K-12 districts requiring instruction generally increases at each grade level through seventh grade and then declines. Eighty-five percent of the 228 responding K-12 districts require HIV prevention education for seventh graders, whereas only 58 percent require it for twelfth graders. Figure 2 shows the percentage of K-12 districts that require HIV prevention education for each grade level. It should be noted, however, that urban and large/suburban districts show the decline beginning in eleventh grade: 81 percent of the urban districts and 85 percent of the large/suburban districts require HIV prevention education in tenth grade compared to 62 percent of the rural/small districts.



Although fewer responding districts require HIV prevention education for their high school students, the average number of hours of instruction is higher in grades 9 through 12 (see Table 2). Older students also are more likely to be instructed about HIV prevention in stand-alone courses or classes, such as assemblies, than are their younger counterparts. The proportion of responding districts using stand-alone instruction ranges between 8 and 10 percent in grades 2 through 7, is 11 percent in grades 8 and 9, 13 percent in grade 10, 19 percent in grade 11, and 23 percent in grade 12. Fifteen percent of the responding districts teach kindergarten students and first graders in stand-alone programs.

Table 2. Grade Level and Hours of Instruction

Grade Level	Percent of K-12 Districts Requiring HIV Education (n=228)	Average Hours of Instruction Per Year
Kindergarten	32%	7.4
1	35	8.4
2	34	8.4
3	39	8.3
4	44	8.9
5	61	9.0
6	72	8.2
7	85	9.0
8	78	9.6
9	72	12.2
10	75	12.0
11	58	11.7
12	58	11.0

Through grade 10, the majority of districts provide HIV prevention education in health education classes (see Table 3). Around the seventh grade, however, instruction begins to shift to science classes and stand-alone programs. By the eleventh grade, only 41 percent of the responding districts use health education classes, and by the twelfth grade, the proportion drops to 34 percent. Social studies classes play a minor role as a vehicle for HIV prevention education until senior high school. Twelve percent of the districts that require HIV prevention education for grade 11, and 14 percent of those that require it for grade 12, provide HIV education in a social studies context.

Table 3. Curricula and Grade Levels in Which HIV Education is Taught*
(% Based on 263 Districts Requiring HIV Prevention Education)

Grade Level	Health Education	Science	Social Studies	Stand Alone
Kindergarten	68 %	5 %	1 %	15 %
1	69	6	1	15
2	66	5	3	8
3	67	5	2	8
4	65	5	2	8
5	70	3	1	9
6	69	5	1	10
7	63	13	2	9
8	63	9	1	11
9	62	8	4	11
10	53	18	2	13
11	41	10	12	19
12	34	9	14	23

*Respondents were permitted more than one answer per grade level.

Curriculum Content and Implementation

Most responding districts teach each of the topics asked about in the survey (see Table 4). Although some sensitive or controversial topics are less likely to be included than others, these topics are taught by a majority of responding districts. Two-thirds (67%) of responding districts include discussion about unprotected oral intercourse as a means of transmitting HIV, 72 percent include discussion of unprotected anal intercourse, 75 percent address death and dying, 80 percent discuss homosexuality, and 84 percent address child abuse.

As seen in Table 4, many of the topics are introduced in the elementary grades by a majority of districts; the remainder are most often introduced in middle school. A significant proportion of responding districts, however, reserve discussions about condoms and unprotected intercourse of any kind for high school.

Responding rural/small districts are somewhat more likely to include communication skills (98%), resistance to peer pressure (100%), self-esteem (99%), and child abuse (88%) in their curriculum than are large/suburban or urban districts. Compared to rural/small and large/suburban districts, urban districts are less likely to include information on death and dying (68%), but are more likely to discuss condoms as a means of reducing the risk of HIV infection (97%), and to discuss the risks of unprotected anal intercourse (81%) and oral intercourse (76%). Responding large/suburban districts are least likely to include discussions of homosexuality (68%). What is taught about any of these subjects is not possible to determine through this survey, however.

**Table 4. Percentage of K-12 Districts that Address Various Topics
in the HIV Education Curriculum
(n=228)**

Topic	Addressed in Curriculum	First Introduced In:		
		Elementary	Middle	High
How HIV is transmitted	99 %	52 %	42 %	4 %
How HIV is not transmitted	100	60	34	3
Fears and myths about AIDS	100	56	36	5
Decisionmaking skills	97	64	29	4
Communication skills	96	66	27	4
Resistance to peer pressure	98	61	31	3
Self-esteem	97	71	22	3
Homosexuality	80	22	56	20
Child abuse	84	76	16	5
Drug use and abuse	98	75	19	2
Death and dying	75	44	33	18
Abstinence from sexual intercourse	99	34	56	9
Abstinence from drug use	100	66	27	5
Condoms	91	14	57	28
Sharing needles	97	45	48	6
Unprotected vaginal intercourse	89	12	60	25
Unprotected anal intercourse	72	8	51	3
Unprotected oral intercourse	67	9	50	39

Of the responding districts that require HIV prevention education, 94 percent allow students to be excused from all or part of the instruction upon a parent's request. Given this flexibility, it is encouraging to note that 80 percent of these districts reported that fewer than one percent of the parents exercise this option; an additional 11 percent reported that between 1 and 3 percent do so. Only one responding rural/small district reported that more than 5 percent of parents seek to have their children excused from HIV prevention education.

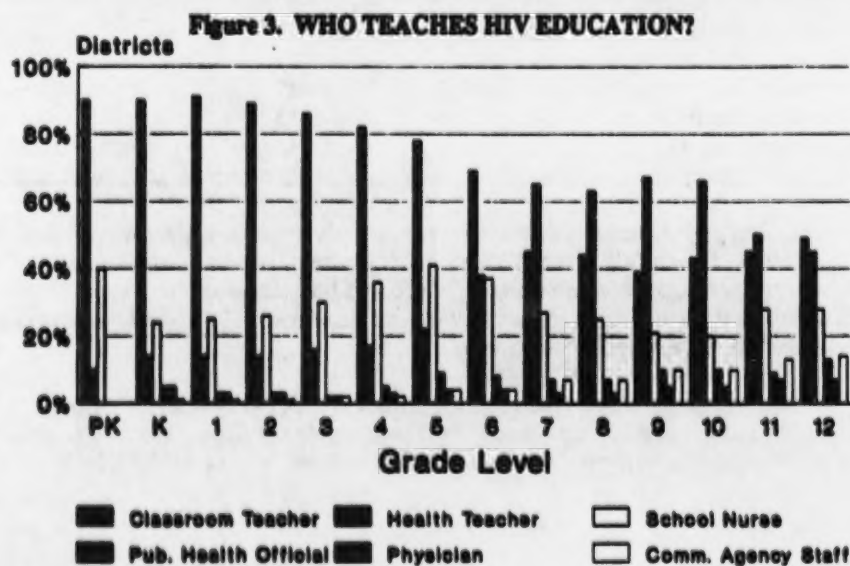
Instructional Personnel

Responding districts report that the classroom teacher most often provides HIV instruction to students in grades kindergarten through grade 6 (see Table 5). Generally, in grades 7 through 12, a health teacher is the primary educator. The proportion of responding districts using school nurses is highest in grades 4 (36%), 5 (41%), and 6 (37%). Non-school personnel play a relatively minor role in educating students about HIV infection. The use of public health officials, physicians, and community agency staff is most prevalent in grades 9 through 12. Figure 3 provides a visual depiction of who teaches HIV education.

**Table 5. Personnel Who Provide Instruction About HIV
in 228 K-12 Districts That Require HIV Education
(Percent by Grade Level)***

Grade Level		Classroom Teacher	Health Teacher	School Nurse	Public Health Official	Physician	Community Agency Staff
Kindergarten	(n=81)	90 %	14 %	24 %	5 %	5 %	1 %
Grade 1	(n=89)	91	14	25	3	3	1
Grade 2	(n=90)	89	14	26	3	3	1
Grade 3	(n=90)	86	16	30	2	2	2
Grade 4	(n=102)	82	17	36	5	3	2
Grade 5	(n=162)	78	22	41	9	4	4
Grade 6	(n=195)	69	38	37	8	4	4
Grade 7	(n=229)	45	65	27	7	3	7
Grade 8	(n=212)	44	63	25	7	3	7
Grade 9	(n=188)	39	67	21	10	5	10
Grade 10	(n=194)	43	66	20	10	5	10
Grade 11	(n=146)	45	50	28	9	7	13
Grade 12	(n=148)	49	45	28	13	7	14

*Totals for each grade level reflect the use of more than one type of instructor.



Based on districts that require HIV education.

Special Education

Eighty percent of the responding districts that require HIV prevention education for their general education students also require instruction for special education students. Generally, urban districts (95%), districts in the Northeast (90%), and those that developed or selected their curriculum with input from community-based organizations (86%) are more likely to require HIV prevention education for special education students.

Moreover, the requirement of instruction for special education students is related to the assessed level of parental support for HIV prevention education. Eighty-five percent of the responding districts that reported high parental support and 81 percent that reported moderate parental support for HIV prevention education also require HIV instruction for special education students; 53 percent of the districts that believe parental support is low require such instruction.

The requirement for HIV prevention education does not apply equally to all classifications of special education students: 78 percent of the districts that require HIV prevention education for special education students require it for students with speech impairments, whereas only 41 percent require instruction for autistic students (see Table 6).

Table 6. HIV Prevention Education Requirements for Handicapped Students

Special Education Students	Percentage of Districts that Require HIV Prevention Education (n=211)
Speech Impaired	78%
Hearing Impaired	70
Mildly Mentally Retarded	72
Emotionally Disturbed	67
Visually Impaired	67
Moderately Mentally Retarded	59
Orthopedically Impaired	57
Multiply Handicapped	55
Autistic	41

Differences also are apparent in data from the urban, large/suburban, and rural/small districts. For example, 80 percent of the urban districts and 77 percent of the large/suburban districts require HIV prevention education for emotionally disturbed students; only 61 percent of the rural/small districts do so. Overall, responding rural/small districts require HIV prevention education for special education students less often than do urban and large/suburban districts.

The median grade level in K-12 districts at which special education students are introduced to HIV prevention education is grade 5, regardless of the handicapping condition. The median grade level for introducing such education to general education students enrolled in K-12 districts also is grade 5.

Teacher Preparation

Eighty-three percent of the responding districts that require HIV prevention education provide their teachers with relevant inservice training. This is especially apparent in the Southern region, where 96 percent report providing such training. Urban districts (92%) and large/suburban districts (94%) provide inservice training at a higher rate than do rural/small districts (78%). Nearly two-thirds (64%) of the districts provide their teachers with written guidelines for instructing students about HIV prevention.

Again, the degree of parental support for HIV prevention education appears related to teacher training. Inservice training is provided in 89 percent of the districts with high parental support, in 78 percent of those with moderate support, and in 53 percent of those with low support. Further, teachers do not receive any special preparation for teaching HIV prevention education in 21 percent of the responding districts with low parental support, nor in 11 percent with moderate support. Only 5 percent of the districts with high parental support for HIV prevention education do not provide any special training for their teaching staff.

Responding districts that established advisory committees to review and recommend appropriate HIV education materials and concepts are more likely to provide training than those that did not. Inservice training is provided by 87 percent of the districts with advisory committees; 71 percent of those without such committees provide such training. Written guidelines are provided by 70 percent of the districts with advisory committees, whereas fewer than half (46%) of the districts without these committees provide guidelines. Nearly one-fifth (19%) of the responding districts without advisory committees do not provide any special preparation for their teachers; only 8 percent of all responding districts that require HIV prevention education do not provide such preparation.

Employee Education

Most of the responding districts require HIV prevention education for school personnel; those that require it for students are more likely to provide it to employees. As shown in Table 7, teachers are the most frequent recipients of HIV education, followed by administrators and guidance counselors.

Table 7. Percentage of Responding Districts That Provide Instruction About HIV Prevention to Staff

Employees	Percent of All Responding Districts (n=332)	Percent that Require HIV Prevention Education (n=263)
Teachers	83%	89%
Administrators	77	82
Guidance Counselors	73	77
School Nurses	71	73
Coaches	69	74
Custodial Staff	61	64
Food Service Staff	58	61
Clerical Staff	55	59
Bus Drivers	50	52

The school nurse most frequently provides instruction to all employees except other nurses. Districts providing HIV instruction to staff report that nurses instructed administrators (42%), teachers (51%), guidance counselors (50%), coaches (48%), clerical staff (57%), bus drivers (54%), custodial staff (55%), and food service staff (52%). School nurses in turn are most often instructed by public health officials (57%).

Costs of Instruction and Infection Control Procedures

Fifty-eight percent of responding districts report that providing HIV prevention education required allocating additional funds from their budgets. Seventy percent of the urban districts and 64 percent of the large/suburban districts allocated additional funds; 54 percent of the rural/small districts reported such allocation. (According to the survey conducted by the National Association of State Boards of Education in May 1989, only seven state education agencies received funds specifically appropriated for HIV education in 1988-89, and eight state education agencies used funds from their general health education budgets to support HIV education.)

Pacific region districts (43%) are more likely than are districts overall (30%) to report that the majority of funds are used for inservice training of teachers (see Table 8). Moreover, 38 percent of the districts in the Pacific region, which are most likely to have purchased their HIV education curriculum, report that the largest share of funds is spent on instructional materials. In comparison, 21 percent of all responding districts report that purchasing instructional materials accounts for the greatest expenditure.

Forty-seven percent of the districts in the Western region and 46 percent of the districts in the Northeast region spent the largest share of funds on curriculum development while only 14 percent of districts in the Pacific region did so. Urban and large/suburban districts allocate funds most often for teacher inservice training, whereas rural/small districts spent the largest share of their funds on curriculum development.

Table 8. Use of Funds to Support HIV Education

Use of Funds	HIV Educ. Req. (n=152)	Central Region (n=35)	Western Region (n=47)	Pacific Region (n=21)	Northeast Region (n=24)	Southern Region (n=25)
Curriculum Development	38 %	34 %	47 %	14 %	46 %	40 %
Teacher Inservice	30	31	26	43	25	28
Purchase of Instruction Materials	21	20	17	38	21	16
Other	7	3	9	5	4	12

Over two-thirds (68%) of all responding districts allocated funds for the 1988-89 school year to support the use of infection control procedures to prevent the spread of disease. Districts with policies on infection control, attendance, and employment of HIV-infected persons, and that require HIV education, are more likely to allocate funds for this purpose than are districts that do not require HIV education (see Table 9). Sixty-nine percent of the districts that allocate funds for infection control procedures spent the largest share of those funds on supplies. Districts that require HIV prevention education spent more on training than districts that do not (see Table 10).

Table 9. Percentage of Districts that Allocated Funds to Support Infection Control Procedures (1988-89 School Year)

	All Districts (n=332)	Policy on Attendance (n=222)	Policy on Employment (n=173)	Policy on Infection Control (n=193)	Require HIV Education (n=263)	Do Not Require HIV Education (n=61)
\$						
Yes	68 %	77 %	80 %	83 %	73 %	46 %
No	29	22	19	15	25	44

Table 10. Use by School Districts of Funds Allocated to Support Infection Control Procedures

Use of Funds	All Districts (n=225)	Require HIV Education (n=191)	Do Not Require HIV Education (n=28)	Infection Control Policy (n=161)
Training	24 %	25 %	14 %	27 %
Supplies	69	68	82	67
Other	1	1	4	n/r

Policies

School board policies direct district efforts to address the HIV epidemic. Seventy percent of the responding districts that require HIV prevention education have adopted an official school board policy addressing HIV education; only 62 percent of the urban districts that require HIV education reported adopting a formal school board policy, however.

Among all responding districts, 80 percent have board-adopted policies on school attendance of HIV-infected students; 61 percent have board-adopted policies on employment of HIV-infected persons; and 68 percent have policies on the use of infection control procedures. Districts that require comprehensive health education or HIV prevention education are only slightly more likely than are other districts to have board-approved policies on student attendance, employment practices, and hygienic procedures (see Table 11).

Table 11. Percentage of Responding Districts with HIV-Related Policies

Policy Topic	All Districts (n=332)	Comprehensive Health Education Required (n=289)	HIV Prevention Education Required (n=263)
Student Attendance	82%	84%	80%
Employment	65	66	61
Hygiene	70	73	68

Fifty-three percent of the responding districts report that their state has issued a policy on attendance by HIV-infected students, and 44 percent report a state policy on employment of HIV-infected persons. The existence of corresponding state policies are reported by 59 percent of those districts with board-approved policies on attendance of HIV-infected students and by 58 percent of those with board-approved policies on the employment of HIV-infected persons. Local leadership apparently can be credited with adoption of policies by school boards where no state requirement exists.

Awareness of Related Issues

As indicators of the risks of HIV infection to adolescents, and thus the need for HIV prevention education, several related topics are important. All districts responding to the survey were queried about their awareness of the teenage pregnancy rate, the prevalence of sexually transmitted diseases among teenagers, and the use of illegal intravenous drugs by students in their community. When considering the relationship of these factors to conditions that also place students at risk of school failure and dropping out of school, the low level of awareness reported is alarming (see Table 12). It may be that school officials are unaware that these data are available from health and social service agencies.

Although awareness of teenage pregnancy rates apparently has little bearing on whether districts require HIV education, responding districts that are knowledgeable about sexually transmitted diseases and intravenous drug use among youth are more likely to require HIV prevention education -- 87 percent and 90 percent, respectively. However, delineating a cause-and-effect relationship from the data is not possible.

Table 12. Percentage of School Districts Aware of Adolescent Risk Factors

Risks	All Districts (n=332)	Urban (n=47)	Large/ Suburban (n=57)	Rural/Small (n=228)
Teenage Pregnancy Rate	59 %	83 %	72 %	51 %
Sexually Transmitted Disease	25	57	42	15
Intravenous Drug Abuse	15	26	21	11

CONCLUSIONS AND RECOMMENDATIONS

The results of this survey merit the attention of school districts that are seeking to develop or expand their HIV education efforts with maximum community support.

Progress

Districts that responded to this NSBA survey have made significant progress in developing and implementing HIV education programs and policies. Indicators of this progress include the following:

- Seventy-nine percent of the responding districts are educating students about HIV, many within the context of comprehensive school health education.
- Public health and community resources are being used in the development and provision of HIV education, and teachers and parents are being involved in the planning process.
- Teachers are receiving inservice training in 83 percent of the districts.
- Local school board policies support and guide educational efforts in 70 percent of the districts that require HIV education.
- Fifty-eight percent of the responding districts have allocated funds to support HIV education.
- Efforts are being made by districts to provide HIV prevention education to students with various handicapping conditions.

Clearly, local schools are recognizing the importance of education to prevent the spread of HIV and are acting to support effective HIV education programs and policies.

Gaps in Program Development and Delivery

Despite the progress being made, however, these survey results also reveal gaps in program development and delivery that should be addressed.

1. There is a significant drop in the percentage of responding districts that require HIV prevention education for students in grades 11 and 12 (see Table 2). Many students are not receiving ongoing reinforcement of the information and skills they need to reduce their risk of HIV infection, particularly before they leave high school for higher education or employment.

Recommendation: Planned and sequential, K-12, comprehensive school health education should be provided for all students, especially students in grades 11 and 12. In the interim, opportunities for integrating HIV prevention education into subjects other than health, which may not be required in grades 11 and 12, should be explored.

2. Where HIV prevention education is required for special education students, the requirements are inconsistently applied to students with various handicapping conditions.

Recommendation: Curriculum should be adapted and teaching strategies developed for educating all handicapped students about HIV prevention.

3. HIV prevention education is provided inconsistently for all school personnel who interact with students. Although 83 percent of the responding districts provide HIV education for teachers, HIV education is provided less often to guidance counselors, coaches, custodial staff, food service staff, clerical staff, and bus drivers (see Table 7).

Recommendation: School officials should recognize that all school employees have a role to play in reinforcing correct information about HIV for students and, consequently, should provide appropriate inservice training and information for various school staff.

4. Rural/small school districts provide HIV education for teachers less often than do urban and large/suburban districts.

Recommendation: Rural/small districts should explore uses of technology, including videotapes, teleconferences, and distance learning, to facilitate effective preparation of teachers and other school personnel.

5. Only 64 percent of the responding rural/small districts have sought the expert advice of health officials and 30 percent have involved community-based organizations when developing or selecting curriculum.

Recommendation: Rural/small school districts should seek assistance from public health officials and representatives of community-based organizations to enhance their expertise about HIV prevention education and to involve the community in implementing such programs.

6. Too many school districts are unaware of factors that indicate the risk of HIV infection for adolescents (see Table 12).

Recommendation: Local school officials should establish communication with local health and social service agencies to assure that data about student health and welfare are shared. School and agency officials should seek ways to cooperate and collaborate on the development and delivery of programs.

Effective Practices

The survey data also reveal some promising or effective practices that might be reinforced and more widely used by school officials.

1. In urban districts, where it may be assumed that more attention has been given to the HIV epidemic by the media and health officials because of the high levels of AIDS cases, parental support is reported as high more often than in large/suburban and rural/small districts.

Recommendation: Districts in areas where there are relatively few reported cases of AIDS to date, and thus less media attention about HIV infection, should provide education programs for parents and school employees that convey the relevance and importance of HIV prevention education for students. For example, students who live in areas where HIV infection is less prevalent may eventually visit or move to areas where it is more prevalent.

2. Eighty-two percent of the responding districts that report high levels of parental support formed advisory committees compared to 32 percent of those with low support from parents.

Recommendation: School districts should establish advisory committees that include teachers, parents, health professionals, and community organization representatives to review and recommend appropriate HIV prevention education materials and concepts to be taught at various grade levels. Rural/small districts in particular should involve the community more to increase parental involvement in, and support for, HIV education.

3. Responding districts that report parental support as high and moderate are more likely than districts that report parental support as low to have a board-approved curriculum.

Recommendation: School boards should officially review and adopt the HIV prevention education curriculum.

4. Sixty-three percent of the responding districts with high parental support have involved the clergy when developing or selecting curriculum, whereas only 37 percent with low support have done so.

Recommendation: All districts should seek ways to involve clergy in developing HIV prevention education.

APPENDIX: RESPONSES TO THE HIV PREVENTION EDUCATION SURVEY

(All data in percentages. Totals may not be 100 percent due to rounding to nearest whole number, respondents who did not answer the question, or where respondents could provide more than one answer.)

		All Districts (n=332)	CUBE (n=47)	LDP (n=37)	RSDP (n=328)
1.	Is comprehensive school health education required as part of your district's K-12 curriculum?	Yes 87 % No 11	77 % 19	91 % 7	88 % 11
2.	Is HIV prevention education required for students in your district?	Yes 79 No 18	79 15	83 18	79 19
3.	If "no" to Question 2:	All Districts (n=61)	CUBE (n=4)	LDP (n=5)	RSDP (n=38)
	Is your district planning to require HIV prevention education?	Yes 61 % No 23 NR 16	57 % 29 14	50 % 10 40	64 % 25 11
4.	If no, what is the primary reason for not doing so?				
	a. See no need	36	50	n/r	46
	b. Community will not support	29	n/r	n/r	21
	c. School Board does not support	7	50	n/r	n/r
	d. Teachers unwilling	n/r	n/r	n/r	n/r
	e. Teachers unprepared	29	n/r	n/r	34
	f. Other	43	n/r	n/r	55

The following questions were answered by those districts that require HIV education.

		All Districts (n=263)	CUBE (n=37)	LDP (n=47)	RSDP (n=179)
5.	In what school year did your district begin providing HIV prevention education for students?	Before 1986 8 % 1986-87 12 1987-88 32 1988-89 37 1989-90 9	27 % 19 35 16 n/r	6 % 15 34 32 11	5 % 10 31 43 10
6.	Has your school board approved the HIV prevention education curriculum for students?	Yes 89 No 11	92 8	81 19	90 10
7.	Has your school board adopted a policy requiring HIV prevention education for the students in your district?	Yes 70 No 29	62 38	70 28	72 27
8.	Does your state require HIV prevention education for school-aged youth?	Yes 80 No 18	73 27	77 21	82 15
9.	Was your HIV prevention education curriculum: (Circle all that apply.)				
	a. Developed within your district	78	87	81	75
	b. Developed by your SEA	34	38	38	32
	c. Mandated by State Board	40	38	26	45
	d. Adapted from available curriculum	51	41	45	55
	e. Purchased	15	14	19	15
	f. Other	9	8	11	9
10.	Is HIV prevention education required for your district's special education students?	Yes 80 No 18	95 5	75 21	79 19

The following questions were answered by those districts that require HIV education for special education students.

		All Districts (n=211)	CUBE (n=35)	LDF (n=35)	RSDP (n=141)
11.	Was the HIV prevention education curriculum for your district's special education students:				
	a. Developed within your district	65 %	63 %	63 %	66 %
	b. Developed by your SEA	26	31	24	24
	c. Mandated by State Board	31	23	17	36
	d. Adopted from available curriculum	48	46	46	49
	e. Purchased	8	6	11	8
	f. Other	10	9	9	11
12.	For each of the following handicapping conditions, indicate if HIV prevention education is required and at which grade level it is first introduced. (Indicate grade level provided).				
	a. Speech impaired	Yes 78 Grade 5.0	77 5.5	77 6.0	78 5.0
	b. Hearing impaired	Yes 70 Grade 5.0	77 5.5	71 6.0	67 5.0
	c. Visually impaired	Yes 67 Grade 5.0	77 5.5	71 5.5	63 5.0
	d. Mildly mentally retarded	Yes 72 Grade 5.0	77 5.0	77 6.0	69 5.0
	e. Moderately retarded	Yes 59 Grade 5.0	74 5.0	63 6.0	55 5.0
	f. Autistic	Yes 41 Grade 5.0	60 5.0	46 6.0	35 5.0
	g. Emotionally disturbed	Yes 67 Grade 5.0	80 5.0	77 6.0	60 5.0
	h. Multiple handicapped	Yes 55 Grade 5.0	74 5.5	57 6.0	49 5.0
	i. Orthopedically impaired	Yes 57 Grade 5.0	74 6.0	69 6.0	50 5.0

The following questions were asked of all districts that require HIV education.

		All Districts (n=263)	CUBE (n=37)	LDF (n=47)	RSDP (n=179)
3.	How are your teachers prepared to teach the HIV prevention education curriculum?				
	a. No special preparation provided	8 %	3 %	6 %	10 %
	b. Written guidelines provided	64	68	79	59
	c. In-service provided	83	92	94	78
	d. Other	13	11	11	14
14.	For each grade level, please indicate if HIV prevention education is or is not required. For those grade levels in which it is required, please identify the curriculum into which it is integrated or whether it is a stand-alone curriculum (e.g., assembly) and how many class hours of HIV prevention education students are required to receive during the school year.				
	Responses to this question are summarized in the report. (Pages 9-11)				
15.	In each grade level, please identify who teaches the HIV prevention education curriculum? Circle all that apply.				

Responses to this question are summarized in the report. Options given were: classroom teacher, health teacher, school nurse, public health staff, physician, community agency staff, other. (Pages 12-13)

16. Please indicate if the following are included in your HIV prevention education curriculum. Also circle the school level (elementary, middle school, or high school) where this information is first introduced.

Grade level responses are summarized in the report. (Pages 11-12)

	All Districts (n=363)	CUBE (n=37)	LDF (n=47)	RSDP (n=179)
a. How HIV is transmitted	99 %	100 %	98 %	99 %
b. How HIV is <u>not</u> transmitted	100	100	98	100
c. Facts and myths about AIDS/HIV	100	100	98	100
d. Decision-making skills	97	93	96	98
e. Communication skills	96	92	92	98
f. Resistance to peer pressure	96	93	94	100
g. Self-esteem	97	93	92	99
h. Homosexuality	80	81	68	83
i. Child abuse	84	78	70	88
j. Drug use and abuse	98	93	96	99
k. Death and dying	75	68	70	78

17. Please indicate if the following behaviors that prevent or reduce the risk of HIV infection are included in your HIV prevention education curriculum. Also circle the school level where this information is first introduced.

Grade level responses are summarized in the report. (Pages 11-12)

a. Abstinence from sexual intercourse	99	100	100	98
b. Abstinence from drug use	100	100	100	99
c. Condoms as a means of reducing the risk of HIV infection	91	97	89	90

18. Please indicate if the following behaviors that put a person at risk of HIV infection are included in your HIV prevention education curriculum. Also circle the school level where this information is first introduced.

Grade level responses are summarized in the report. (Pages 11-12)

a. Unprotected vaginal intercourse	89	92	92	88
b. Unprotected anal intercourse	72	81	70	71
c. Unprotected oral intercourse	67	76	62	66
d. Sharing needles	97	100	100	96

19. Who from your community was involved in the development of your HIV prevention education curriculum for students? Circle all that apply.

a. Public health officials	71	89	85	64
b. Teachers	94	92	96	94
c. Parents	79	84	83	77
d. Clergy	33	37	37	34
e. Students	38	49	38	36
f. Community-based organizations	41	78	33	30
g. Other	39	43	26	27

20. Was a school/community advisory committee established to review and recommend appropriate HIV prevention education materials and concepts to be taught at various grade levels?

Yes	73	87	77	68
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21. Does your district provide HIV prevention education to parents?

Yes	49	60	60	44
-----	----	----	----	----

22. How would you assess parental support for HIV prevention education in your schools?

High	36	78	55	52
Medium	33	14	34	36
Low	7	5	2	9

23. Does your district have procedures in place for parents to ensure their children from all or part of the HIV prevention education instruction?

Yes	94	97	96	92
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24. Answered only by those districts that answered "Yes" to Question 23.

What percentage of parents in your district have assessed their children from HIV prevention instruction since the curriculum was introduced?

	All Districts (n=246)	CUBE (n=36)	LDP (n=45)	RSDP (n=165)
a. Less than 1%	80 %	81 %	75 %	81 %
b. Between 1 and 5%	11	17	11	9
c. Between 5 and 9%	2	3	n/a	3
d. More than 9%	<1	n/a	n/a	1

25. Answered by those districts that require HIV education.

Has the provision of HIV prevention education required allocation of additional funds from the school district's budget?

	All Districts (n=263)	CUBE (n=37)	LDP (n=47)	RSDP (n=179)
Yes	58 %	70 %	64 %	54 %

26. Answered by those districts that answered "Yes" to Question 25.

The largest percentage of these funds is allocated for:

	All Districts (n=151)	CUBE (n=26)	LDP (n=30)	RSDP (n=96)
a. Curriculum development	38 %	35 %	33 %	41 %
b. Teacher inservice	30	39	37	25
c. Purchase of instructional materials	21	15	17	34
d. Other	7	8	10	5

The remaining questions, except question 26, were asked of all districts.

	All Districts (n=333)	CUBE (n=47)	LDP (n=57)	RSDP (n=328)
27. Do you know the teenage pregnancy rate in your community?				
Yes	59 %	83 %	72 %	51 %
28. Do you know how many teenagers in your community contract a sexually transmitted disease each year?				
Yes	25	57	43	15
29. Do you know how many teenagers in your community have injected cocaine, heroin, or other illegal drugs?				
Yes	15	26	21	11
30. Has your state issued a policy on school attendance by HIV-infected students?				
Yes	53	53	63	50
31. Has your board adopted a policy on school attendance by HIV-infected students?				
Yes	80	94	86	75
32. Has your state issued a policy on employment of HIV-infected persons?				
Yes	44	49	54	40

	All Districts (n=332)	CUBE (n=47)	LDF (n=57)	RSDP (n=228)
33. Has your board adopted a policy on employment of HIV-infected persons?				
Yes	61 %	77 %	74 %	55 %
34. Has your board adopted a policy to require the use of hygienic procedures to prevent the spread of disease?				
Yes	68	79	68	66
35. Has your district allocated funds in 1988-89 to ensure that hygienic procedures to prevent the spread of disease are practiced?				
Yes	68	72	68	67
36. Answered by those districts that answered "Yes" to Question 35.				

The largest percentage of these funds has been expended on:

	All Districts (n=225)	CUBE (n=34)	LDF (n=39)	RSDP (n=152)
a. Training	34 %	29 %	38 %	22 %
b. Supplies (e.g., rubber gloves, disinfectants)	69	71	64	70
c. Other	1	n/t	3	1
37. For which school district employees is HIV education provided and who provides that instruction? Circle all that apply.				

Responses to the second half of the question are summarized in the report. (Page 15)

Education provided to:	All Districts (n=332)	CUBE (n=47)	LDF (n=57)	RSDP (n=228)
Administrators	77 %	85 %	72 %	77 %
Teachers	83	94	77	82
School Nurses	71	83	77	67
Guidance Counselors	73	75	70	73
Counselors	69	75	61	69
Choirial Staff	55	62	53	54
Bus Drivers	50	55	51	49
Custodial Staff	61	68	54	61
Food Service Staff	58	66	51	59

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Susan P. Merry

Michael A. Resnick

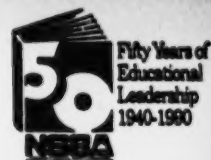
August W. Steinhilber

*Executive Committee

**Executive Committee Member *ex officio*

***Attends Executive Committee meetings as a non-voting observer

about NSBA . . .



The National School Boards Association is located in Alexandria, Virginia, within the Washington, D.C., metropolitan area. NSBA is a not-for-profit organization whose primary mission is the general advancement of public education through the unique North American system of representative and participatory government, whereby elementary and secondary school policy is decided by local school board members who are directly accountable to the community. Over 95% are elected, and the remainder are appointed by elected officials.

Federation Members of NSBA are the state associations of local school boards, the Hawaii State Board of Education, and the boards of education in the District of Columbia and the U.S. Virgin Islands.

NSBA promotes the quality of public elementary and secondary schools through services to its Federation Members and local school boards; by increasing school board impact on federal education laws and regulations; and by maintaining liaison with other education organizations and governmental authorities.

In so doing, NSBA represents the interests of school boards before Congress, federal agencies and in court cases relating to education; provides education and training programs for school board members; provides school district management services; and offers to school boards a variety of other services including an annual convention and the Institute for the Transfer of Technology to Education (ITTE).

The NSBA Federal Relations Network, composed of up to three school board members in each Congressional district, plays a major role in NSBA's education advocacy program in Washington, D.C.

Three major publications are produced by NSBA: the award-winning monthly magazine, *The American School Board Journal*; the monthly magazine, *The Executive Educator*, and a fortnightly newspaper, *School Board News*.

Eight constituent groups within the Federation play a significant role in NSBA's efforts to serve Federation Member and school board needs:

- The Council of Urban Boards of Education focuses on the needs of urban school boards.
- The Large District Forum serves the special needs of large but non-urban school districts.
- The Rural District Forum serves rural and small enrollment districts.
- The Federation Member Executive Directors' NSBA Liaison Committee links the top executives within the Federation.
- The Council of School Attorneys focuses on issues of school law.
- The Conference of School Boards Association Communicators serves NSBA and Federation Member communications professionals.
- The Federal Policy Coordinators Network focuses on the administration of federally funded programs.
- The Technology Leadership Network serves as a forum for sharing information about technology in the classroom and school district operations.

NSBA maintains close liaison with other groups, such as the National Caucus of Black School Board Members, National Caucus of Hispanic School Board Members, National Caucus of Young School Board Members, National Association of State Boards of Education, American Association of School Administrators, Forum of Education Organization Leaders (FEOL), Educational Leaders Consortium (ELC), National Governors' Association, National Conference of State Legislatures, and Education Commission of the States.

Founded in 1940, NSBA represents the nation's 97,000 school board members who, in turn, represent the more than 40 million public school children in the U.S., who account for about 90% of all elementary and secondary school students in the nation. About 1,800 local school boards are NSBA Direct Affiliates.

NSBA policy is determined by a 150-member Delegate Assembly composed of active school board members across the country. Translating this policy into action programs is a Board of Directors consisting of 21 members and three ex-officio members. The executive director administers NSBA programs, assisted by a professional staff.



National School Boards Association
1680 Duke Street
Alexandria, VA 22314
(703) 838-6722
FAX: (703) 683-7590